DEPARTMENT OF HEALTH AND HUMAN SERVICES										
CENTERS FOR MEDICARE & MEDICAID SERVICES										
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION								

				(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL		
		155664	B. WIN		-	07/14/2	011	
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER			4102 SI	HORE DR			
	KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CF		EK	INDIAN	IAPOLIS, IN46254			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
F0000								
	This wisit was for	u the Investigation of	F0	000				
		r the Investigation of	FU	000				
	Complaint IN000	J93147.						
	Complaint IN00093147-Substantiated,							
	•	ciencies related to the						
		ted at F224, F328, and						
	F514.	ted at 1224, 1328, and						
	F314.							
	Survey dates: Ju	1, 12 % 14 2011						
	Survey dates. Ju	11y 13 & 14, 2011						
	Facility number:	010666						
	Provider number							
	AIM number: 20							
	111111111111111111111111111111111111111							
	Survey team: Joy	yce Hofmann, RN						
	Census bed type:							
	SNF/NF: 101							
	Total: 101							
	10001. 101							
	Census payor typ	ne:						
	Medicare: 40							
	Medicaid: 32							
	Other: 29							
	Total: 101							
	Sample: 3							
	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.							
					ļ			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RA7A11

Facility ID:

010666

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155664		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/14/2011		
	PROVIDER OR SUPPLIER	CARE AND REHAB- EAGLE CRE	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN46254				
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OR Quality Review of	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) completed on July 19,		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F0224 SS=D	written policies and mistreatment, neg and misappropriat Based on observate record review, the facility staff answitimely manner for meeting minutes residents interview concerns. Findings include Resident call light 07/13/11 during if at 10 a.m. until 1 were observed to and no call lights extended period of Resident call light 07/14/11 at 4 p.m. immediately by the Nursing [ADON]. Interview with R at 12:15 p.m., income answered okay designed and mistapped oxiging the second of the second of the second oxiging the second of the second oxiging the second oxi	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. Action, interview, and the facility failed to ensure evered call lights in a cor 3 of 9 resident council reviewed and 3 of 6 towed for call light. The swere observed on the facility of the facility of the facility of time. The swere observed on the facility of time.	FC	224	Enclosed, please find our correction for the deficient identified duriing the comparity of July 14, 2011. If acility respectfully request desk review of our plan of correction. We believe the historically we have democommitment to our plans correction and that we had delivered consistent qualifoutcomes. We would appryour consideration of this request. It is the practice of facility to do everything with power to prohibit the mistreatment, neglect, and of residents and misapproform of resident property. 1. Re #D and #E no longer residentify. Resident #H has monitored routinely to hele ensure call light is being answered more promptly. Resident #H's roommate stated during interview by and DNS on 7/15/10 that is being answered by staft timeframe of 2 to 5 minute faster. 2. The facility will of to conduct call light audits shifts to include weekends department managers and	cies as blaint The ts a at at anstrated of ve ty eciate f the thin our d abuse opriation sident de in the been o #I State call light f within es or ontinue s by	08/02/2011

STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155664	B. WIN			07/14/2	011
NAME OF	DDOLUDED OD GUDDU IEI		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	K		4102 SI	HORE DR		
		CARE AND REHAB- EAGLE CRE	EK		APOLIS, IN46254		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	minutes for the staff to answer as the				monthly in resident council meeting to determine if other	-	
	staffing seems to	be less on the			possible call light concerns h		
	week-ends.				been identified. The		
					Administrator and/or designe	e will	
	Interview with F	Resident #E on 07/13/11 at			investigate identified concern		
	12:55 p.m., indi	cated call lights are			and assure individualized fol	low	
	answered most of	of times up to 30 - 40			through. Resident Council Meeting 7/29/11 showed no	call	
	minutes or longe	er, week-ends are bad,			light concerns identified.3. T		
	_	staff on week-ends as they			Staff Development Coordina		
	are few and far l				re-educated staff on 3/11/11,		
	Interview with Resident #F on 07/14/11 a				6/6/11 and again on 7/14/11		
					include weekend staff on 7/1		
		ated it takes staff 5 to 10			on call light policy and proce It is standard practice for fac		
	_				to review call light policy and		
	minutes to answ	er nis can fight.			procedures quarterly. ADNS with resident council on 6/24	met	
	Interview with F	Resident G on 07/14/11 at			review the Call Light Policy a		
	5:30 p.m., indica	ated it takes staff 10			assure them that the facility		
	minutes at most,				its management take this po	-	
	<u> </u>	,			very serious and will continu	e to	
	Interview with R	Resident H on 07/14/11 at			ensure call lights answered timley.4. Administrator will re	aview	
		ated it takes sometimes 15			call light audits in monthly Q		
	1 .	utes once in a while.			Assurance meeting for the n		
	inniaces, 50 mm	ates once in a wine.			three months and quarterly		
	Interview with F	Resident I on 07/15/11 at			thereafter to ensure and mor quality compliance.5.	nitor	
		ated it takes staff 2 to 5			Administrator will ensure		
	_	r to answer call lights.			compliance by 8/2/11.		
	Resident Counci	il Meeting Minutes, dated					
		ted the call lights were					
	being answered	C					
	Resident Council Meeting	il Meeting Minutes, dated					
	11/26/10, indicated one resident indicated						
	call lights were	not being answered					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CO		(X3) DATE COMPL	
ANDILAN	or connection	155664		ILDING	00	07/14/2	
			B. WI		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				HORE DR		
KINDREI	D TRANSITIONAL C	CARE AND REHAB- EAGLE CR	EEK	INDIAN	APOLIS, IN46254		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENC1)		DATE
	timely.						
	Resident Council	l Meeting Minutes, dated					
		ed no call light concerns.					
	12/1//10, marea	od no dan nghi dondonis.					
	Resident Council	Meeting Minutes, dated					
		ed call lights needed to					
	be answered time	ely and it was worse on					
	2nd and 3rd shift	S.					
		I Meeting Minutes, dated					
		ed call lights needed to					
		ely and indicated 1/2					
	hour wait at least	to be answered.					
	Resident Council	l Meeting Minutes, dated					
		27/11, indicated no call					
	light concerns.	27711, maicated no can					
	8						
	Resident Council	Meeting Minutes, dated					
	06/24/11, three r	residents indicated the					
	staff cut off the c	all lights and do not					
		notes indicated an audit					
	1	night shift was completed					
		had been addressed. The					
		ne residents were pleased					
	and had no furthe	er concerns.					
	Daview of the facility's policy on call						
Review of the facility's policy on call lights entitled, Use of Call Light, dated							
09/26/03, indicated, "Rationale The call light is a communication tool for the resident to request assistance." The		_					
	1	esponding to a Call Light					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPL 07/14/2	ETED	
	OVIDER OR SUPPLIER	ARE AND REHAB- EAGLE CREE	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR					
(X4) ID PREFIX TAG	(EACH DEFICIENCE REGULATORY OR	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) for the location of the		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
Iti Continue to the second of	ight, and answer Go to the location urn off the light. his/her needs, unlessistance with an he assistance of a tursing assistant. eplace call light Review of the fact lated 10/31/09, in exual, physical, corporal punishme eclusion, and newell as mistreatments appropriation trictly prohibited for 07/14/11 at 10 Administrator presented by the Over the past we conducted by the Over the past we conducted a call lights answered to the 67 answered to the 67 answered to the formal that the formal that the formal trictly prohibited to the formal trictly prohibited	glect of the resident as tent, neglect, and of resident property are l. 2:38 a.m., the esented a Call Light						

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Event ID:

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Facility ID:

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155664	B. WING			07/14/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L		4102 SI	HORE DR		
	O TRANSITIONAL (CARE AND REHAB- EAGLE CREE	K	INDIAN	APOLIS, IN46254		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	_	is related to Complaint					
	IN00093147.						
	3.1-27(a)(3)						
F0328 SS=D	proper treatment a special services: Injections; Parenteral and en Colostomy, ureter Tracheostomy car Tracheal suctionin Respiratory care; Foot care; and Prostheses. Based on intervict facility failed to document a residential to the color of the colo	ostomy, or ileostomy care; e;	F0:	328	It is the practice of the facility ensure taht residents receive proper treatment and care fo special services.1. Resident no longer resides at facility.2 There were no other residen with trachs affected with not appropriately assessing and documenting tracheostomy of upon review.3. Nursing staff been re-educated on 10-25-11-30-10, 12-4-10, 4-25-11,	e r # B ts care	08/02/2011
	assessment. [Re	sident #B]			6-30-11,7-16-11 and most recently on 8-1-11 on the importance on assessing and documenting on residents wi		
					trachs. Unit Managers/ADNS and/or designee daily review	s	
	1). Resident #B's closed clinical record was reviewed on 07/13/2011 at 12 p.m.,				trach residents to ensure		
					appropriate documentation is		
		e resident was admitted to			completed and resident is be	-	
	•	/12/2010 and had			assessed when changes to t have been made and/or care		
	•	included, but were not			been changed to include price		
	limited to, end st	age renal disease with			and upon return from LOA.4.		

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155664	B. WIN			07/14/2	U11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	D TO ANOITION AL C	ADE AND DELIAD. EAGLE ODE			HORE DR		
KINDREI	D TRANSITIONAL C	CARE AND REHAB- EAGLE CRE	:EK	INDIAN	APOLIS, IN46254		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re l	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		tina	DATE
	dialysis, secondary to diabetic neuropathy, hypertensive nephrosclerosis, acute				Director of Nursing is conduct weekly audits of chart	ung	
	**	·			documentation to help monit	or for	
		re, diabetes, trachea			continued compliance and w		
	malasia, bacterer	<u>-</u>			report findings to Quality		
		tant staphylococcus			Assurance meeting for the natural three months and quarterly	ext	
	· ·	obstructive pulmonary			thereafter. The Director of		
		nsion, gastroesophageal			Nursing weekly audits consis	st of	
		besity, stage I diastolic			assessment and documenting	g on	
	heart function, ar	nd left toes amputee.			tracheostomy care patients t		
					include prior to and upon retouted from LOA, threshold will be r		
	Resident #B's ho	spital records, dated			when consistent documentat		
	11/02/2010, indicated the resident had				and assesssment on all tracl		
	been on hemodialysis for six years and				patients remain in place on a		
	had received a left transmetatarsal				ongoing basis and monitored	d on a	
	amputation on 10	nputation on 10/13/2010 for gangrene			quarterly basis to ensure continued compliance.5. Dir	ector	
	and the resident l	had a Taylo-Achilles			of Nursing will ensure compl		
	lengthening perc	lengthening percutaneous of the left			by 8-2-11.		
	Achilles tendon.	The resident's past					
	diagnoses includ	ed, but were not limited					
	to, tracheal malas	sia with prior					
	reconstruction, st	tatus post tracheotomy in					
	August 2010, dys	slipidemia, status post					
	recent cardiac an	d respiratory arrest, when					
		ived the trach, and					
	multiple recent re	•					
	·						
	Admission physi	cian orders, dated					
	11/12/10, indicat						
	ĺ	re not limited to, trach					
	care every shift, suction every shift as						
		d oxygen [o2] at 4 liters					
	with humidity 28%.						
	Resident Progres	s Notes dated 11/12/10,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155664	A. BU	ILDING	00	07/14/2	
		133004	B. WI		DDDDGG GENY GENERAL GEN GODD	07/14/2	
NAME OF I	PROVIDER OR SUPPLIER			I	DDRESS, CITY, STATE, ZIP CODE		
KINDREI	O TRANSITIONAL (CARE AND REHAB- EAGLE CRI	EEK		APOLIS, IN46254		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)		TAG	DLI ICILICI I		DATE
	several times this	ach in place suctioned					
	encouraged to co						
	encouraged to co	ugii					
	Resident Progres	s Notes, dated 11/13/10,					
	indicated, "Neb [
	· '	in. [administered].					
		es] 1. Pt. [Patient] able					
	to cough up some						
	<i>S</i> 1	1					
	Resident Progres	s Notes, dated 11/14/10,					
	indicated, "lung	g sounds congested upper					
	lobes"						
	Resident Progres	s Notes, dated 11/15/10,					
	indicated, "Res. s	suctioned x 3 this shift					
	secretions thick of	e [with] blood present"					
		one Orders, dated					
	· ·	ed, "(1) Trach in place is					
	1	less, place spare @ [at]					
		24% per trach mask c					
		0 3 lpm [liters per					
	3 \ /	tion trach q [every] 4					
	• •	ce ambu @ bedside (4)					
	_	saline @ times of sx					
		oms] as needed. (5) R.					
		Therapy] to change trach					
	• • • •	Check O2 sats q shift &					
	prn."						
	Resident Progress	s Notes, dated 11/18/10,					
		lent request cough syrup -					
	-	going to Dialysis s					
	states 1 ve beell	going to Diarysis s					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED
		155664	B. WIN			07/14/2011
			_		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER			4102 SI	HORE DR	
	D TRANSITIONAL (CARE AND REHAB- EAGLE CRE	EEK	INDIAN	APOLIS, IN46254	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	.	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION) [without] a coat - now I have a cough"		+	TAG	DEFICIENC!)	DATE
	1	· ·				
	left lung rhonci.	"				
	Resident Progres					
	· ·	cated, " pt. [patient]				
	states she has no	t been able to tolerate				
	capping - feels sl	ne can't breathe when on.				
		s Notes, dated 11/21/10,				
	· ·	s only needed to be				
		fter pt. swallowed some				
	food that "went of	lown the wrong pipe."				
	Resident Progress Notes, dated 11/24/10, indicated, "Res. A [Alert] & O [Oriented] x 3, res. has thick secretions et may need additional breathing tx to loosen secretions. No c/o [complaint of] SOB [shortness of breath] or pain. Resp. [Respirations] even et non-labored"					
		eal record indicated a				
	1	onsibility for Leave of				
		ident #B with a sign out				
	date of 11/25/10	at 5 p.m.				
	Interview with th	ne complainant on				
		5 a.m., indicated on				
		dent left the facility for				
	Thanksgiving wi	· ·				
	complainant indicated the resident got					
something stuck in her throat, 91		•				
	_	sident was suctioned.				
		crew had no normal saline				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLI	ETED
		155664	B. WIN			07/14/20	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	HORE DR		
KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CRE			EEK	1	APOLIS, IN46254		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	to help with the						
	complainant's si	ster called the facility to					
	let them know w	hat was going on and					
	asked if they sho	ould bring the resident					
	back to the facili	ity. The family was told					
	by staff that the	resident should be alright					
	1 *	eep her until midnight.					
]						
	Interview with I	PN #3 on 07/13/11 at					
		ated she recalled Resident					
	_	d they were at home and					
		y and said the resident					
	1	ten and got choked and					
	1	_					
	1	ould bring her back to the					
	1	11. LPN #3 indicated she					
		resident was choking, call					
	911.						
	Interview with the	he complainant's sister on					
	07/14/11 at 12 p	.m., indicated the resident					
	started coughing	and coughing again and					
	her cousin called	1911 and the paramedics					
	came and suction	ned the resident and got					
	out what they co	ould as they did not have					
	1	The complainant's sister					
	1	d her son returned the					
	resident to the fa	icility and when she					
		d the facility to have					
	1	nem to help get the					
	resident into the						
	complainant's sister indicated they waited						
1 ^		no one showed up and her					
	1	ent out and into the					
	1 -	mplainant's sister					
	1 -20-1110 001						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			INSTRUCTION 00	(X3) DATE COMP	
		155664		LDING		07/14/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF I	PROVIDER OR SUPPLIER			1	HORE DR		
KINDREI	D TRANSITIONAL C	CARE AND REHAB- EAGLE CR	EEK	1	APOLIS, IN46254		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		came to suction the					
	resident and she put the resident's night clothes on her and left the facility. The						
	_	ter called her that night					
		t was in the cannula and					
		something green and the					
	resident had eate	n greens for supper.					
	Interview with L	PN #2 on 07/14/11 at					
	12:42 p.m., indic	ated Resident #B did					
	leave the facility	on Thanksgiving and					
	recalled her com	ing back to the facility					
	and somebody fr	om out staff was with					
	them. LPN #2 in	idicated the resident					
	wanted to be suc	tioned and had her					
	portable oxygen	with her. LPN #2					
	indicated she suc	tioned the resident and					
	she had a mucou	s plug, pretty good size,					
	color was dark b	rown and mucousy. LPN					
	#2 indicated she	cleaned and took out the					
	inner cannula and	d changed it out and					
	showed it to the	resident. LPN #2					
	indicated the resi	dent was fine after that.					
	LPN #2 indicated	d family was in the room					
	at the time of suc	etioning. LPN #2					
	indicated Resider	nt #B always wanted					
	suctioned and wo	ould get panicky and want					
	suctioned again.	LPN #2 indicated they					
	were trying to we	ean the resident off,					
	trying to cap her	off, and she couldn't					
	stand to be cappe	ed off. LPN #2 indicated					
	the sisters were concerned we were not						
	suctioning her, b	ecause the resident got so					
	anxious.						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETE	ED	
		155664	B. WIN			07/14/2011	1	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	1		
NAME OF F	PROVIDER OR SUPPLIER	S.			HORE DR			
KINDRFI	TRANSITIONAL (CARE AND REHAB- EAGLE CRE	FK	1	APOLIS, IN46254			
							(V.5)	
(X4) ID		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	OMPLETION DATE	
IAG	REGULATORT OR	ESC IDENTIFTING INFORMATION)	+	IAG			DAIL	
	T D3 T // 2 ' 1' .							
	LPN #2 indicated							
	07/15/11 at 10:30 a.m., that she went							
	straight into the	room with the resident						
	and family when	they returned to the						
	facility Thanksgi	iving night. The resident						
	was in no distres	s and I suctioned the						
	resident and the	family was right there.						
	The clinical reco	ord lacked documentation						
	of resident assessment before the resident							
	left the facility, what happened on leave							
	•	when she returned to the						
	facility.	when she returned to the						
	lacility.							
	The resident's cli	inical record lacked						
		f the resident's leave of						
		dent at home and 911						
	· ·	ed, and them not being						
	_	-						
	_	ly suction the resident,						
		the family in regards to						
		facility about bring the						
		d asking for assistance to						
	bring the residen	t back into the facility.						
	Dagidant Dragger	ng Notes, detect 11/27/10						
	_	ss Notes, dated 11/27/10,						
	·	states she has the most						
		llowing food that gets						
		at. Has worn PMV valve						
		tolerates well. Pt states						
	she has not been	able to tolerate being						
	capped off becau	se she feels she can't						
	breathe"							

AND PLAN OF CORRECTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: 155664 (X2) MUL A. BUILD B. WING		ILDING	07/14/2011					
	PROVIDER OR SUPPLIER	L CARE AND REHAB- EAGLE CRE	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	indicated, " Ne 1 only this shift	ss Notes, dated 11/28/10, reded suctioning x [times] a small piece of food or at she couldn't cough						
	indicated, " Re of] not being abl Neb [Nebulizer] administered the Trach lavaged ar large thick muco	n suctioned c little help. ad suctioned again. A us plug dislodged. Inner and resident resting c no						
	11/30/10, indicate to #4 Shirley cuff cap during the datrach cap @ noc during the day. breath, dryness)	anone Orders, dated seed, "(1) Downsize trach ffless (2) Cap trach c red ay as tolerated, Remove [night] or if not tolerated (SOB [shortness of (3) O2 2lpm per NC orn while trach is capped 88%."						
	dated 11/30/10, in alert, respiration breathing pattern rest at 98%, breather decreased, trach on 11/30/10, track	espiratory Assessment, ndicated the resident was rate of 16, heart rate 78, a unlabored, o2 room air th sounds clear and size #4 Shirley changed th weaning PMV cap, al, trach position midline,						

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/14/2011	
	PROVIDER OR SUPPLIED	Ⅱ R CARE AND REHAB- EAGLE CRI		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL SELSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	needs/comments "Resident is in h Therapy] @ bes session. Writer that her trach ch verbalizes under @ this time to # Change went we [After] trach cha trach capping to understanding b will attempt. Tr red cap. No dist noted. Nursing There was no nu documentation of the Resident Pro 11/30/10, after d being notified by downsizing in th Resident #B's cl lacked documen assessment on a on 11/30/10 ever Administration of documented cor trach care, suction Speech Therapy had seen the resident	osed clinical record tation of nursing ll 3 shifts for this resident n though Medication Records [MAR] were rectly as having provided oning, and O2 sats and and Respiratory Therapy						

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED		
		155664	B. WIN			07/14/2011		
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER	<u>t</u>		4102 SI	HORE DR			
KINDREI	D TRANSITIONAL (CARE AND REHAB- EAGLE CRE	EEK	INDIAN	APOLIS, IN46254			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)	DATE		
	1	lent returned from						
		7ital signs] 160/85, hr						
	[heart rate] 80 r [respirations] 16 t							
	1	94% O2 sat, eating						
	· ·	ot finished, I think I need						
	to be suctioned."	Suctioned resident x's 3						
	- c little (clear m	ucous) return, changed						
	cannula. States '	'It feels better now."						
	Resident coughe	d clear mucous into						
	tissue. Encouraged to cough & spit							
	often."							
	Another Resident Progress Note, dated							
		a.m., which indicated,						
		info to eve [evening]						
	_	lso explained that R.						
		is very apprehensive						
		& capping. Continue to						
	1	ent to "cough up" as much						
	I -	is entry was noted to be						
	1 ^	was written on the back						
	of notes dated 12	L/UL/ 1U.						
	Intomio	DN #1 on 07/12/11 -4						
		PN #1 on 07/13/11 at						
		ted the above entry was a						
	1	ould have been circled.						
		the indicate the resident						
		the cap on and she was						
	really anxious.							
		.						
		ne Respiratory Therapist						
		1 at 3:10 p.m., indicated						
		the resident's trach on						
	11/30/10, as it wa	as impeding her airway,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2)	MULTIPLE CO			(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00		COMPL	
		155664	B. W	ING			07/14/2	011
NAME OF I	PROVIDER OR SUPPLIEI	R		STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
					IORE DR			
KINDRE	D TRANSITIONAL (CARE AND REHAB- EAGLE	CREEK	INDIANA	APOLIS, IN4625	54		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S P	PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG	ŧ	R LSC IDENTIFYING INFORMATION)		TAG	DEF	FICIENCY)		DATE
		could not remember						
	which nurse he talked to when he passed							
		on to nursing. The RT						
	indicated he asse	esses the resident and						
	addresses any is	sues the resident might						
	have. The RT in	ndicated he was never						
	notified by nursi	ing for any concerns, but						
	indicated if a nu	irse comes to him, he goes						
	and assesses the	resident and provides						
	services if there is concerns.							
	The facility's policy for Documentation of							
	Resident's Healt	th Status, Needs and						
		evised date of 10/31/09,						
		onale The resident's						
		is a continuing account of						
		alth status and needs, the						
		ered, results of diagnostic						
		ident's response to						
		Interdisciplinary Team						
		care of the resident is						
		recording assessments of a						
	_	tion, changes in the						
	1	tion, changes in the						
		,						
		and an evaluation of the						
		ess toward established						
		tine, periodic review of a						
		status may be required						
	1 .	ion." The policy's						
		ated, " Document as						
		dent's encounter is						
		sure accurate recall of the						
		entation in a resident's						
	medical record s	should be: a. Consistent						
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			IULTIPLE COI LDING	NSTRUCTION 00	СОМ	E SURVEY PLETED		
		155664	B. WIN			07/14	/2011	
	PROVIDER OR SUPPLIER D TRANSITIONAL C	CARE AND REHAB- EAGLE CRE	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN46254					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	Objective, d. Factorial of the resident" Objective, d. Factorial of the resident" Organized, g. Continued of the resident of the resident"	Procedure also indicated, ent resident data that may mited to: a. change in and ongoing monitoring ective data that validates etion taken d. hysician (name and ation of family (name and ent) f. Results of labs and ensultations h. Any mal occurrence i. All nade or received that are ident j. Refusals, behavior occurrences k. eents - document the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155664		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 07/14/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE HORE DR	•	
KINDREI	D TRANSITIONAL (CARE AND REHAB- EAGLE CRE	EK	1	APOLIS, IN46254		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	•	TAG	DEFICIENCY)		DATE
F0514 SS=D	each resident in a professional stand complete; accurat accessible; and sy	naintain clinical records on ccordance with accepted lards and practices that are ely documented; readily stematically organized.					
	information to ider the resident's asse and services provi preadmission scre State; and progres Based on intervi	ew and record review, the	F0	514	It is the practice of this facilit	•	08/02/2011
	facility failed to clinical record, rea resident's assess had been down-swho felt the need suctioned, and faresident's assessal leave of absence facility after an it to be called out for resident's trached reviewed in a sar care and assessm. Findings include 1). Resident #B' was reviewed on and indicated the facility on 11 diagnoses which limited to, end st.	document in a resident's esident progress notes of sment and condition who sized to a new trach and it to be frequently siled to document a ment of condition before a and after return to the incident in which 911 had for suctioning of the a for 1 of 3 residents mple of 3 for tracheotomy tent. [Resident #B]			maintain clinical records on resident and to document in resident's clinical record, resprogress notes of a resident assessment and condition whave been down-sized to a trach.1. Resident # B no lor resides at facility.2. There who other residents with trachaffected with not appropriate assessing and documenting tracheostomy care upon review.3. Nursing staff has re-educated on 10-25-10, 11-30-10, 12-4-10, 4-25-11, 6-30-11,7-16-11 and most recently on 8-1-11 on the importance on assessing and documenting on residents where trachs. Unit Managers/ADN and/or designee daily review trach residents to ensure appropriate documentation is completed and resident is be assessed when changes to have been made and/or care been changed.4. The Direct Nursing is conducting weeklaudits of chart documentation	a sident 's who new nger were ns elly been d ith S ws seing trach e has or of y	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155664		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMP 07/14/2	LETED
		100004	B. WIN		DDDDGG GETY GTATE GIR GODE	0771472	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE HORE DR		
KINDRE	D TRANSITIONAL	CARE AND REHAB- EAGLE CRI	EEK		APOLIS, IN46254		
(X4) ID	1	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE PRIATE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)	+	TAG	help monitor for continue	٠	DATE
	1 **	phrosclerosis, acute			compliance and will report		
	respiratory failure, diabetes, trachea malasia, bacteremia secondary to methacillin resistant staphylococcus aureus, chronic obstructive pulmonary disease, hypertension, gastroesophageal				findings to Quality Assura		
					meeting for the next three		
					and quarterly thereafter.		
					Director of Nursing weekl consist of assessment ar		
					documenting on tracheos		
	•	obesity, stage I diastolic			care patients to include p		
	heart function, a	and left toes amputee.			and upon return from LO, threshold will be met whe		
	Resident #B's he	ospital records, dated			consistent documentation		
	11/02/2010, indicated the resident had been on hemodialysis for six years and				assesssment on all trach		
					patients remain in place ongoing basis and monito		
		ceived a left transmetatarsal			quarterly basis to ensure	nea on a	
		0/13/2010 for gangrene			continued compliance. 5.		
	_	had a Taylo-Achilles			Director of Nursing will er	ensure	
		cutaneous of the left			compliance by 8-2-11.		
		. The resident's past					
		ded, but were not limited					
	to, tracheal mala	-					
		status post tracheotomy in					
	•	yslipidemia, status post					
	1 -	nd respiratory arrest, when					
		eived the trach, and					
		·					
	multiple recent	resuscriations.					
	Admission phys	sician orders, dated					
		ted orders which					
	included, but we	ere not limited to, trach					
		suction every shift as					
	-	d oxygen [o2] at 4 liters					
	with humidity 2						
	Resident Progre	ss Notes, dated 11//12/10,					
	indicated, " Tr	rach in place suctioned					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPI		
		155664	B. WIN			07/14/2	011
	PROVIDER OR SUPPLIER			4102 SH	DDRESS, CITY, STATE, ZIP CODE HORE DR	•	
		CARE AND REHAB- EAGLE CRE	=EK	<u> </u>	APOLIS, IN46254		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	several times this encouraged to co						
	indicated, "Neb [[treatments] adm Suctioned x [time to cough up some Resident Progres indicated, "lung lobes" Resident Progres indicated, "Res. s secretions thick of Physician Teleph 11/15/10, indicate a #6 Shirley cuffl bedside. (2) O2 [with] O2 flow (a minute] (3) Suc hours & prn, plac Lavage c normal [signs and sympt T. [Respiratory T	in. [administered]. es] 1. Pt. [Patient] able					
	indicated, "Resid states "I've been	s Notes, dated 11/18/10, lent request cough syrup - going to Dialysis s now I have a cough"					

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A BUILDING B. WING COMPLETED 07/14/2011 NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) left lung rhonci" Resident Progress Notes, dated 11/20/2010, indicated, " pt. [patient] states she has not been able to tolerate capping - feels she can't breathe when on. Resident Progress Notes dated 11/21/10 indicated, " Has only needed to be
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Resident Progress Notes, dated 11/20/2010, indicated, " pt. [patient] states she has not been able to tolerate capping - feels she can't breathe when on. Resident Progress Notes dated 11/21/10 STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN46254 STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN46254 (X5) COMPLETION DATE (ACCH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE Resident Progress Notes, dated 11/20/2010, indicated, " pt. [patient] states she has not been able to tolerate capping - feels she can't breathe when on. Resident Progress Notes dated 11/21/10
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Resident Progress Notes, dated 11/20/2010, indicated, " pt. [patient] states she has not been able to tolerate capping - feels she can't breathe when on. Resident Progress Notes dated 11/21/10 4102 SHORE DR INDIANAPOLIS, IN46254 ID PROVIDERS PLANOF CORRECTION (AS5) (CMPLETION COMPLETION DATE (AS5) (COMPLETION DATE
KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Resident Progress Notes, dated 11/20/2010, indicated, " pt. [patient] states she has not been able to tolerate capping - feels she can't breathe when on. Resident Progress Notes dated 11/21/10 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE (X5) COMPLETION DATE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Resident Progress Notes, dated 11/20/2010, indicated, " pt. [patient] states she has not been able to tolerate capping - feels she can't breathe when on. Resident Progress Notes dated 11/21/10 Resident Progress Notes dated 11/21/10
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Resident Progress Notes, dated 11/20/2010, indicated, " pt. [patient] states she has not been able to tolerate capping - feels she can't breathe when on. Resident Progress Notes dated 11/21/10 Resident Progress Notes dated 11/21/10
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Resident Progress Notes, dated 11/20/2010, indicated, " pt. [patient] states she has not been able to tolerate capping - feels she can't breathe when on. Resident Progress Notes dated 11/21/10
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states she has not been able to tolerate capping - feels she can't breathe when on. Resident Progress Notes dated 11/21/10
capping - feels she can't breathe when on. Resident Progress Notes dated 11/21/10
Resident Progress Notes dated 11/21/10
Lindicated " Has only needed to be Till I Ti
suctioned x 1 - after pt. swallowed some
food that "went down the wrong pipe."
Resident Progress Notes dated 11/24/10
indicated, "Res. A [Alert] & O [Oriented]
x 3, res. has thick secretions et may need
additional breathing tx to loosen
secretions. No c/o [complaint of] SOB
[shortness of breath] or pain. Resp.
[Respirations] even et non-labored"
The closed clinical record indicated a
Release of Responsibility for Leave of
Absence for Resident #B with a sign out
date of 11/25/10 at 5 p.m.
Interview with the complainant on
07/14/11 at 11:25 a.m., indicated on
11/25/10 the resident left the facility for
Thanksgiving with family. The
complainant indicated the resident got
something stuck in her throat, 911 was
called and the resident was suctioned.
The emergency crew had no normal saline
to help with the lavaging. The

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664		<u> </u>	ILDING	NSTRUCTION 00	(X3) DATE COMPL	ETED
NAME OF I	DDOWNED OD CUDDI IEI	<u> </u>	D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIE				HORE DR		
KINDRE	D TRANSITIONAL	CARE AND REHAB- EAGLE CRI	EEK	INDIAN	APOLIS, IN46254		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	` `	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
1710	ŧ	ster called the facility to		1/10			DITTE
		hat was going on and					
	asked if they should bring the resident						
	1	ity. The family was told					
		resident should be alright					
	and they could k	eep her until midnight.					
	Interview with LPN #3 on 07/13/11 at						
	4:50 p.m., indicated she recalled Resident						
	#B going out and they were at home and						
	called the facility and said the resident						
	was eating chicken and got choked and						
	1	ould bring her back to the					
	1 -	11. LPN #3 indicated she					
	911.	resident was choking, call					
	911.						
	Interview with t	he complainant's sister on					
		.m., indicated the resident					
	_	and coughing again and					
	her cousin called	d 911 and the paramedics					
	came and suctio	ned the resident and got					
	1	ould as they did not have					
		The complainant's sister					
		d her son returned the					
		ncility and when she					
		d the facility to have					
		nem to help get the					
	resident into the						
	_	ster indicated they waited					
		no one showed up and her					
	_	ent out and into the mplainant's sister					
	1	e came to suction the					
	I marcaica no one	cume to suction the					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE COMPI	LETED
		155664	B. WIN			07/14/2	2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
KINDDEI	D TOANGITIONAL C	CARE AND REHAB- EAGLE CR	EEV		HORE DR APOLIS, IN46254		
				<u> </u>	APOLIS, IN40254		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	DATE
	resident and she	put the resident's night					
	l '	d left the facility. The					
	complainant's sister called her that night						
	and told her wha	t was in the cannula and					
	indicated it was s	something green and the					
	resident had eate	n greens for supper.					
	Interview with LPN #2 on 07/14/11 at						
	12:42 p.m., indicated Resident #B did						
	leave the facility on Thanksgiving and						
	recalled her coming back to the facility						
	and somebody from out staff was with						
		ndicated the resident					
		tioned and had her					
	1	with her. LPN #2					
		tioned the resident and					
		s plug, pretty good size,					
		rown and mucousy. LPN cleaned and took out the					
		d changed it out and					
		resident. LPN #2					
		dent was fine after that.					
		d family was in the room					
		etioning. LPN #2					
		nt #B always wanted					
		ould get panicky and want					
		LPN #2 indicated they					
	_	ean the resident off,					
	trying to cap her	off, and she couldn't					
	stand to be cappe	ed off. LPN #2 indicated					
	the sisters were c	concerned we were not					
	suctioning her, b	ecause the resident got so					
	anxious.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	li i	TE SURVEY IPLETED		
	155664			A. BUILDING B. WING			07/14/2011	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CRE			STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	(X5) COMPLETION DATE		
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL							
		s Notes, dated 11/28/10, eded suctioning x [times]						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
	155664		B. WI			07/14/	07/14/2011	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CRE			STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR EEK INDIANAPOLIS, IN46254					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE	
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL							
		section indicated,						

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN46254 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) COMPLETING DATE	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 4102 SHORE DR INDIANAPOLIS, IN46254 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	
KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH ORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY PROVIDERS PLAN OF CORRECTION FROM PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	
TAG REGULATOR OR ESCHIEFTING INTORNIATION) TAG STATE	DΝ
"Resident is in her room c ST [Speech	
Therapy] @ beside having a therapy	
session. Writer explained to res [resident]	
that her trach change was due. Res.	
verbalizes understanding. Trach changed	
@ this time to #4 Shirley cuffless.	
Change went well c no complications. p	
[After] trach change writer explained	
trach capping to res. Res verbalizes	
understanding but is reluctant to try, but	
will attempt. Trach capped @ this time c	
red cap. No distress or complications	
noted. Nursing informed of changes."	
There was no nursing assessment	
documentation of resident assessment in	
the Resident Progress Notes dated	
11/30/10 after down-sizing the trach nor	
being notified by RT in regards to the	
downsizing in the trach size.	
Resident #B's closed clinical record	
lacked documentation of nursing	
assessment on all 3 shifts for this resident	
on 11/30/10 even though Medication	
Administration Records [MAR] were	
documented correctly as having provided	
trach care, suctioning, and O2 sats and	
Speech Therapy and Respiratory Therapy	
had seen the resident that day.	
The next entry is dated 12/01/10, which	
indicated, "Resident returned from	
Dialysis. V/S [Vital signs] 160/85, hr	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155664		(X2) N	MULTIPLE CO	NSTRUCTION 00	li i	TE SURVEY MPLETED			
		1 ' '	A. BUILDING B. WING			07/14/2011			
			B. WII		DDRESS, CITY, STATE, ZIP CO				
NAME OF PROVIDER OR SUPPLIER				4102 SHORE DR					
KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CRE			EEK	INDIAN	APOLIS, IN46254				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		RECTION	(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SECTION SECTIO		COMPLETION		
TAG		respirations 16 t	+	TAG	BEIGERAT		DATE		
	' ' '	94% O2 sat, eating							
		ot finished, I think I need							
	· ·	Suctioned resident x's 3							
		ucous) return, changed							
	· ·	'It feels better now."							
		d clear mucous into							
		ged to cough & spit							
	often."								
	Another Residen	t Progress Note, dated							
	12/01/10 at 2:20 a.m., which indicated, "Reported Trach info to eve [evening]								
	shift nurse Also explained that R.								
	T. states resident is very apprehensive								
	concerning trach & capping. Continue to								
	1	nt to "cough up" as much							
		is entry was noted to be							
		was written on the back							
	of notes dated 12/02/10. Interview with LPN #1 on 07/13/11 at 2:45 p.m., indicated the above entry was a late entry and should have been circled. LPN #1 went on the indicate the resident would not leave the cap on and she was really anxious.								
	Interview with the Respiratory Therapist [RT], on 07/13/11 at 3:10 p.m., indicated								
	1	he resident's trach on							
	11/30/10, as it was impeding her airway,								
		could not remember							
	which nurse he talked to when he passed								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155664		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		B. WIN			07/14/2	2011		
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CRE			EEK	4102 SH	ADDRESS, CITY, STATE, ZIP CODE HORE DR APOLIS, IN46254	 		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
TAG	on the information indicated he asses addresses any iss have. The RT indicated, but indicated in the resident's heat treatment. The Indicated in the caresponsible for resident's condition of interventions are sident's progressioutcomes. Routing resident's health and per state regulation indicated in the resident's health and per state regulation. Procedure indicated in the resident in the resident indicated in the resident indicated in	on to nursing. The RT sses the resident and ues the resident might dicated he was never cated if a nurse comes to assesses the resident and s. icy for Documentation of a Status, Needs and vised date of 10/31/09, nale The resident's a continuing account of a lith status and needs, the cred, results of diagnostic dent's response to nterdisciplinary Team are of the resident is ecording assessments of a on, changes in the on, a detailed accounting and an evaluation of the ses toward established ne, periodic review of a status may be required on." The policy's ted, " Document as		TAG			DATE	
	Objective, d. Factual, e. Accurate, f. Organized, g. Complete, and h.							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155664					NSTRUCTION 00	(X3) DATE : COMPL		
		A. BUI B. WIN	LDING NG		07/14/2	011		
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CRE			STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN46254					
	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHAB- EAGLE CRISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Timely" The Procedure also indicated, " record pertinent resident data that may include but not limited to: a. change in condition/illness and ongoing monitoring b. Selected subjective data that validates or clarifies c. Action taken d. Notification of physician (name and status) e. Notification of family (name and relation to resident) f. Results of labs and follow-up g. Consultations h. Any unusual or abnormal occurrence i. All telephone calls made or received that are related to the resident j. Refusals, noncompliance, behavior occurrences k. Events and accidents - document the details of the event, action taken, notifications, monitoring, and follow-ups. l. Communication with others regarding the resident" This federal tag is related to Complaint IN00093147. 3.1-50(a)(1)			STREET A	HORE DR	1	(X5) COMPLETION DATE	
	3.1-50(a)(2)							